Long Term Care Covid-19 Commission

Ministry of Health - Vision for Ontario Health Teams
on Monday, November 16, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 16th day of November, 2020, 11:00 a.m. to 11:59 a.m.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:

Amy Olmstead, Acting Executive Lead, Ontario Health Teams Division
Allison Costello, Acting Director, Implementation and Supports Branch, Ontario Health Teams Division

OBSERVERS:
Jillian Paul, Acting Director, Integrated Policy and Planning Branch, Ontario Health Teams Division
Amy Leaman, Counsel to Ministry of Health and Ministry of Long-Term Care

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat

John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead of the Long-Term Care Commission
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Sanjay Bahal, Team Lead, Operations, Long-Term Care Commission Secretariat
Judith Parker, Counsel, Crown Law Office, Civil
Roopa Mann, Ministry of the Attorney General

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

-- Upon commencing at 11:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): So we're here. Who's leading the group? Oh, okay. Ms. Olmstead. So I'm Frank Marrocco. I don't think we've met before, although we seem to be dragging people here from the Ministry on a regular basis. But in any event, this is Commissioner Dr. Jack Kitts and Commissioner Angela Coke.

AMY OLMSTEAD: Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): We are the Commission. There's yourself and Ms. Costello. And are you expecting anyone else?

AMY OLMSTEAD: Yes. Also expecting our colleague, Jillian Paul.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, we'll wait a minute, then. Anyway, welcome.

AMY OLMSTEAD: Thank you. If you have everyone at your end, we'd be pleased to start a few minutes early. I will be starting with the slide deck, so it would be fine if Jillian joins us in a few minutes.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, we're all here.

AMY OLMSTEAD: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): So we're ready when you are. If that's fine, you want to start, go right ahead.

AMY OLMSTEAD: Okay. Great. And does it make sense, is it the most effective use of your time if I go through the presentation in some detail and obviously pausing for whenever you may have questions?

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, that's fine. Thank you. That works for us. It has in the past, anyway.

AMY OLMSTEAD: Great. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): We're okay with that, yes, by the way.

AMY OLMSTEAD: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

AMY OLMSTEAD: Great. Wonderful. And thank you, Judith, for putting the presentation up on this screen. I appreciate it. So I think I'm going to use my own version here at this end.

So looking at -- so I'll just jump right in. My name's Amy Olmstead, acting executive lead of the Ontario Health Teams Division. Really

pleased to be here today to provide some background on the Ontario Health Teams' initiative and answer questions and talk a little bit about our experience to date with respect to Ontario Health Teams, and with a particular focus on long-term care, obviously.

So I'll start with a little bit of background on Ontario Health Teams and then go into sort of our more recent experience.

So the Ontario Health Team model is really based on a made-in-Ontario approach based on learning that we've seen and work that we've seen in other jurisdictions.

So obviously in the industrialized world, we, governments, and populations are facing similar challenges with respect to healthcare. We have many providers across multiple care sectors leading to potential gaps, duplication, lack of coordination, and over-reliance on hospitals and an under-reliance on primary care, not enough attention to self-management and preventative healthcare and financial incentives that are not aligned and reinforce that siloed experience of the health system.

So what we've seen in other

jurisdictions is a move towards integrate and accountable care systems, and these systems share the same features. So they share the financial and clinical accountability for the quality of care and for the patient and client experience and for the overall costs of care.

The services are integrated with a focus on and a foundation of primary- and community-based care. The payment methods and incentives are built to deliver value and not simply pay for volumes of services, and there is a flexible approach to that care delivery model that allows for innovation and tussive change.

So based on the well-documented experience in other jurisdictions, the Ministry moved to create Ontario Health Teams.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just ask, Ms. Olmstead --

AMY OLMSTEAD: Certainly.

COMMISSIONER FRANK MARROCCO (CHAIR): -- how did they divide up the province?

AMY OLMSTEAD: Mm-hm. So the Ministry, and I'll ask Allison to say more about this, but generally, the Ministry, recognizing what a significant change this would be to move from our

siloed approach to healthcare to an integrated, on-the-ground, partnership-based approach, the Ministry made a decision to encourage local partnerships and to encourage those local partners in care delivery to get together and build the partnership, the specific partners and client or patient populations of focus that made sense for them.

We supported those discussions with a significant amount of data that would help local health providers identify the services that the people in their regions were using. So what were those patient models? Where were they going for care? How were they using care?

So we've encouraged those partnerships to evolve locally, and that's -- where we are right now is we are seeing a lot of partnerships come together where, I think, around 80 percent of the population is covered with these partnerships now.

And we continue to work with both the OHTs that have been approved as well as OHTs that are in development to continue to work to determine how to cover the whole population and what are the right partnership groupings for that.

Allison, can I ask you to provide any

additional information about how we determine this approach to --

COMMISSIONER ANGELA COKE: I've got a question.

AMY OLMSTEAD: -- coverage?

ALLISON COSTELLO: Absolutely. Good morning. I'm Allison Costello. I'm the director of the OHT Implementation and Supports Branch in the Ministry.

So as Amy said, the process that we had in place at the beginning was to really have teams come together based on partnerships that they had in place and really learn from them as we go to understand what that could look like at maturity.

So you had sort of asked, how do we divide up the province. So we started by hearing from teams how they saw themselves coming together, and we used a lot of data to help us understand how patients currently and most recently have accessed care and how those patients tend to kind of swirl above a network of providers. And it's not so much lines on a map, but the population that a community of providers through an OHT would support that we have a good sense through the data we have available of how that might be organized.

But it's not so much lines on map, and again, as we're sort of supporting teams to be approved through a staged process over time, we have a sense of what that will look like. We have a sense through the teams that have been approved right now and the networks that we have been discussing with them that they'll care for over time and at a more mature state and what that would look like.

So we have a sense based on the data how teams will be organized, and it's not so much lines on maps but as about the populations that they'll support and the providers within those networks that will all be part of a partnership over time.

COMMISSIONER FRANK MARROCCO (CHAIR): When they're recognized, what does that mean? When they're approved?

AMY OLMSTEAD: Thank you. So we have a phased approach for implementing Ontario Health Teams, and we'll chat about that a little bit more.

Right now, the Ontario Health Teams that are approved are ones that, we believe, have met the requirements that we've set out in the guidance document for Ontario Health Teams in terms

of the range of providers that they have included in their partnership and their plans to work together in the future.

Right now, being approved means they can call themselves Ontario Health Teams, and they're eligible for funding support to continue their development around, for example, collaborative decision-making.

Allison, do you want to outline in a little bit more detail the stages ultimately ending at designation?

ALLISON COSTELLO: Absolutely. So the approval is a concept that we've set out within the guidance document that we've released that the minister will approve Ontario Health Teams based on a number of criteria that we had defined that sort of says they're ready to get started, they're ready to begin the work, they've identified a year-one population that they plan to support, but there's a long way to go between that year-one population and being able to support a full population with the inclusion of every partner within that network and every patient within that network.

So we had developed a staged approach to assess teams' readiness to move forward with the

minister being the approver at the end of that stage, and what's set out in the legislation is that, at maturity, these teams can be designated to become Ontario Health Teams, which would allow them to receive an integrated funding envelope from the funder of Ontario Health.

That is at a point in time that they would be inclusive of all partners; demonstrate the maturity of being able to receive an integrated funding envelope. It would also demonstrate that the agency itself has that maturity as well and that all the partners are being cared for, in a way.

So we had kind of set out a Stage 2, approved them to begin their work, and our approval of them has sort of said you're approved to begin your year-one planning, and we want to be able to support them and sort of put particular markers in the sand to understand how their maturity is progressing so that we can understand when an integrated funding and an integrated accountability approach will be appropriate.

We do see that being down the road at some time based on that layer, just caring for one kind of sliver of their population at this time.

AMY OLMSTEAD: And just to add to that -- apologies. So right now, the accountability and oversight and funding for the partners within an OHT, and even an approved OHT, it's still the previous funding arrangements and oversight and accountability structure. So hospitals still have all of their direct funding agreements and their oversight and accountability responsibilities.

So that is the current state. We are encouraging that shared planning and then encouraging the collaborative decision-making with an eye at maturity to getting that more-integrated accountability and funding arrangement.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you. Commissioner Coke?

COMMISSIONER ANGELA COKE: I'm just trying to understand a bit more about what would be the difference between this concept and model of integration versus what was envisaged with the Local Health Integration Networks?

AMY OLMSTEAD: Hm. I would say that the -- you know, certainly the LHINs and moving home and community care into the LHINs was intended to give the Local Health Integration Networks

oversight of many parts of the health system.

I think a difference with the Ontario Health Team model is that partnership is at the foundation and the shared decision-making, but I wouldn't want to speculate further than that.

Allison, you were obviously there while this was being worked out. Is there --

ALLISON COSTELLO: Yeah.

AMY OLMSTEAD: -- anything you wanted to add?

ALLISON COSTELLO: Yeah, and I think with the exception of your example, Amy, about home and community care, the LHINs are administrators. So the LHINs hold the accountability relationship with the providers. Ontario Health Teams will be the providers, the planners, the ones that provide the care for their patients. They will be the collective of the different health service providers, together acting as one team.

That will still have an accountability relationship with the funder overall, but the LHINs were established to be planning, funding, and integrating with the local health system, not the providers of. So there's a step below of kind of integrating the system to do and be the care

provider for all the population that they're serving, that the LHINs, with the exception of home care, didn't hold that service provision function.

COMMISSIONER ANGELA COKE: Okay.

AMY OLMSTEAD: Great. Thank you for those questions. We will probably be able to add some layers to our responses as we go through the deck. So if we go to Slide 3 -- I'll just move to Slide 3 here.

So to support the creation of Ontario Health Teams, The People's Health Care Act received royal assent, and that created the Connecting Care Act, which is the supporting legislative infrastructure for Ontario Health Teams.

So they are a new model of integrated care delivery that will enable patients, families, communities and providers and system leaders to work together, innovate, and build on what is best in Ontario's healthcare system now by tackling that really key issue of integration. So the goal is for the groups of healthcare providers to work together as a team to deliver the full continuum of care for patients in a coordinated way.

And they will have common -- they'll be working to achieve common goals related to improved

health outcomes, improved patient and provider experience, and, of course, value for money, value for the funding that we're investing in our health system.

So as we talked about, the current funding and accountability mechanisms will remain in place in the near term. OHTs, as we've talked about, they've come together as a network of partners. They're doing a lot of planning, and they're starting to create collaborative decision-making models, but they are not at a level of -- a place of maturity where they have shared accountability for the services that the network of partners provides.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just ask: We've heard that in Wave 1, dealing with long-term care facilities, there was a shortage of trained staff trained in the use of personal protective equipment and so on.

Am I right in understanding that the Ontario Health Teams at this stage of their development, it's a bit early for them to be involving the different partners in filling those needs? Am I right or not?

AMY OLMSTEAD: They were not

accountable or required to do so as part of where they are in their development, but what we did see and what we're happy to speak to in a couple of slides is that OHTs were using the partnerships and relationships that they had started to develop to support their network partners. So we did see that happening as a result of their work to date as OHTs.

But to your point, no, they didn't have a new accountability necessarily to do so, to help or to provide resources to their partners, but we did see them -- we did see examples of where that was happening.

COMMISSIONER FRANK MARROCCO (CHAIR): So when you say a new accountability, you mean they weren't mandated to do it?

AMY OLMSTEAD: As part of the -- right. As part of their OHT status at this point and the accountabilities or what it means to be an OHT right now, that's correct. They weren't required to step in and devote resources to one of their system partners, but we did see them do that as a result of the relationships they've built.

And, of course, there were also, then, ministry mechanisms or government mechanisms where

we were supporting the cross-deployment of resources as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

COMMISSIONER JACK KITTS: Just to clarify: So I think what you're saying is that a hospital, the primary care physicians, the home and community care, all of the partners in an OHT ultimately are accountable still to their boards and their governing bodies, and they're responsible to deliver the mandate that they've been given as individual silos.

But getting together for the past year or two did create relationships that, while not mandatory or mandated, did lead to integrative activities because of existing relationships and, in those cases, worked very well.

And right now, what I think you're saying is that at a certain level of maturity, the Ontario Health Team will work as a unit with a governing body, a funding envelope, and a responsibility to look after a population as opposed to their own individual mandate; is that where this is going?

AMY OLMSTEAD: Yes. That is exactly

correct. Thank you for saying it so clearly.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, Commissioner Coke?

COMMISSIONER ANGELA COKE: So I just want to understand: In the current state now, once the OHTs are set up, who oversees them now?

AMY OLMSTEAD: In the current states, the various partners within an OHT are overseen by their existing accountability relationships, so that may be to the LHIN; that may be directly with the Ministry. It would depend on the particular partner.

COMMISSIONER ANGELA COKE: Okay. But the OHTs, they're getting some additional funding as an entity --

AMY OLMSTEAD: Yes.

COMMISSIONER ANGELA COKE: -- and the overseeing of that. I understand the individual partners have their straight-line accountability, but right now, you have an entity; you are giving it money; there is some sort of agreement that's in place that has to be followed.

So I'm just trying to understand: Who is overseeing that coordinated entity?

AMY OLMSTEAD: Great. Thank you for

clarifying. So the funding arrangements are not yet in place. We expect that they will happening soon, and that will be a funding agreement between the Ministry and the OHT or the partner within the OHT responsible for holding the funding. So the Ministry will have that accountability relationship for the deliverables related to that particular funding envelope, and that funding is really intended to support the development of the OHT as opposed to service delivery.

Allison, you've been working on those agreements. Is there anything that we should add there that would be helpful to this answer?

ALLISON COSTELLO: I think you covered it, Amy, and there are some slides that speak to it a little bit later. It is about the teams that have come together for and established a collaborative decision-making arrangement process.

So the funding is related to their work together but does not replace their existing accountability structures. It is about the work that they're undertaking as a collective and how that funding can support them and related to their progress as an OHT and what they'll achieve together, the reporting that they would make to the

Ministry based on that.

COMMISSIONER FRANK MARROCCO (CHAIR): Do I understand that the decision-making, that the Ontario Health Team decision-making model is collaborative? So what do they do? Would they take a vote? I mean, is it binding on the members?

So if the team takes a decision that requires a long-term care facility to do something, is that binding on the long-term care facility, or can they say "No, we don't think so"? How do they impose their -- how does that work?

AMY OLMSTEAD: So I'm going to ask Allison or Jillian to provide some additional information about that.

I will say, off the top, that what the particular governance structure will look like, that collaborative governance is still something that we are working through. I think it represents the peak maturity of the model to be able to engage in that kind of meaningful collaborative decision-making that does, you know, bind or have an impact on all partners.

ALLISON COSTELLO: And I can start certainly on that point. We, in the summer, released some guidance for collaborative

decision-making arrangements that we hoped would be helpful to teams to understand what we hoped that they'll put in place and what we would expect to see in place reflecting their current state of coming together, which is, as you said it, Commissioner, early stages, and sort of reflects that they're coming together to make decisions that are in support of their year-one objectives, reflecting how they will distribute the implementation funding the Ministry is giving to them.

They will be decisions that are sort of in the realm of that -- thank you, Judith -- related to kind of what we think they should have in place as far as their structures, the inclusion of different representative groups across it, and ask teams to make those decision-making arrangements, you know, including that list that you'll see there on Slide 14, but that it is not -- we have not sort of said this is the terms of reference; these are the legal documents you have to follow; this is how we think you should include your board representation or what you need to clear with your board, each provider, as you undertake this. Each provider is determining how they're

coming to the table and attesting to this relationship that we're asking them to make.

So it is very unlikely that it would be to the level of decisions that would alter accountability arrangements that they already have in place, as it is kind of reflecting their early stages of implementation.

COMMISSIONER FRANK MARROCCO (CHAIR): The reason I was asking the question -- and I'm sorry for belabouring this, but I'm having some difficulty. You know, we're dealing with an emergent -- we're dealing with looking back at Wave 1 and, I think related to that, trying to figure out whether Wave 2 is going to look any different than Wave 1.

And so we're dealing with a situation, I think, that you could fairly call an emergency, and I was trying to understand how direction is given in a situation like that. But it sounds like maybe that's for a time later on when the health team has matured more; it's a bit premature to ask that question now.

AMY OLMSTEAD: I think that's an accurate assessment that the -- our actual expectations of OHTs at this time would not include

binding collaborative decision-making. So that's not a tool that we had in the first wave, and it's not a tool that we will have in the second wave with respect to accountabilities and resource allocation related to COVID, for example.

It's a learning that we are actively engaged in as we think about OHTs at maturity, for sure. We think that the experience during COVID has pointed to the value of this type of locally driven collaborative partnership model, but we do recognize and you all recognize with your questions that we are a distance away from that. But that is the path that we are working on.

COMMISSIONER FRANK MARROCCO (CHAIR): Right. And I think you're -- I mean, I think a person could easily come to the conclusion that locally driven decisions are going to be better and more nimble than a centralized decision-making structure, especially in an emergency.

AMY OLMSTEAD: Well, and I think it speaks to the variable -- how the health services have evolved over time in different parts of the province and the variable impact of the emergency but also the variable capacity.

In some communities, you might have a

hospital that has a different capacity or primary care that has a different capacity than in others, so it speaks to where do we have the strength of resources in order to be able to assist Partner X or Partner Y, which I think is another -- as you say, it speaks to the power of a local model.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Commissioner Coke?

COMMISSIONER ANGELA COKE: Just a few things for clarification: So provider participation in a team is voluntary?

AMY OLMSTEAD: At this stage of development, yes, we are asking willing partners to come together.

COMMISSIONER ANGELA COKE: Okay. So a long-term care home could say "Yay, I'm in" or "I'm not interested"?

AMY OLMSTEAD: At this time, it is voluntary. The end-state vision of Ontario Health Teams is the full continuum of care, including long-term care.

COMMISSIONER ANGELA COKE: Okay. And just in terms of public health units, are they in the scope and mix of this?

AMY OLMSTEAD: It's anticipated that

Public Health, like all other health providers, will be part of the OHTs at maturity as well.

COMMISSIONER ANGELA COKE: Are there any that have been involved in the ones that have been developed to date?

COMMISSIONER JACK KITTS: I can answer that. Allison, I think you probably can too.

Yes, in Ottawa, one of the -- the local Ontario Health Team which I was involved with for a couple of years does have Public Health present.

COMMISSIONER ANGELA COKE: Thanks.

AMY OLMSTEAD: And Judith has kindly put on the screen the list of Ontario Health Teams who already have long-term care partners.

ALLISON COSTELLO: And I might just add a caveat to that page before you jump off it, Judith, is that that was based on the full applications and the partners at that point, and we do know from our conversations with some of the teams that are not listed here that they do have LTC participating in some way now. So we do think that it has increased over the past year.

COMMISSIONER ANGELA COKE: Great.

JILLIAN PAUL: I would say the same for Public Health as well.

ALLISON COSTELLO: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think we've stopped asking questions, so go ahead.

AMY OLMSTEAD: All right. We'll go back to the slide deck, and I think we can go through a couple of slides quite quickly because you all clearly understand the goal of an OHT and the value of having that full, coordinated continuum of care that we've talked about in order to promote the most effective use of the health system resources and promote health outcomes and patient and family experience, particularly regarding transitions during their care journey.

And we've talked about, at maturity, having a single clear accountability framework with an integrated funding envelope. So very much focused on the quadruple aim.

So if we go to Slide 5, a little bit of an illustration here in terms of how we've asked the Ontario Health Teams as they plan to think about how to expand and deepen their work, and what we've asked them to do is to identify year-one priority populations as a starting point.

And we saw some variation in terms of

the year-one priority populations, which is to be expected, and again, that's around really leveraging the local knowledge about where the greatest impact could be felt with a focus on a particular population, or, in some cases, they may be building on strengths that they already have in a particular area or within a particular network, and they want to really leverage that for their planning to obviously support their entire patient and client population at maturity.

COMMISSIONER ANGELA COKE: So, sorry. I have --

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke, you have a question?

COMMISSIONER ANGELA COKE: -- a question. Mm-hm. Just in terms of -- I mean, I'm just trying to understand this in sort of practical terms. When we talk about, you know, better connect the care, who in your model, who is the one [indecipherable] integrator for the patient as they move through whatever continuum of care that you have in place?

AMY OLMSTEAD: Well, we certainly want to encourage a no-wrong-door approach, and the integrator, we think, will vary based on the client

or patient population.

So there may be -- we certainly want to encourage primary care as an integrator. When I think of home and community care, which is also in our division, the linkages between home and community care and primary care is a very powerful partnership.

We see a model where, you know, Mrs. Kumar has been going to her family doctor, her primary care provider for a number of years, and she's reached the point where she needs additional supports at home, that, you know, the model where someone within that primary care practice is able to then connect her with home care and have that home care overseen by that primary care practice.

So that would be one type of model of integration, but certainly, our expectation on Ontario Health Teams is that there would be improved transitions for Mrs. Kumar when she goes to hospital, if she goes to hospital, and then comes out, that it's not that siloed experience.

So one of the challenges we've given OHTs is to think through and test models to improve that integration through the care journey.

All right. If we look at the next

slide, 6: So we've spoken a fair bit about this in terms of the collaborative decision-making structures, expectations regarding shared clinical pathways, unified strategic plans and integrated quality improvements, planning our key components of an OHT.

We also are really emphasizing patient and family engagement. We know that's important for all parts of the care experience but certainly as OHTs are underway in planning new models and developing them, that engagement with patients and families will be really critical.

So I think we've addressed the other parts of that slide, so I think I'm going to hand things over to Allison to walk through the -- give a snapshot or sort of a status update in terms of where we are with OHTs and long-term care.

ALLISON COSTELLO: Thanks, Amy. So on the slide you see here, we've just sort of emphasized some points related to long-term care within OHTs, and as we've noted in the appendix, we do have a list of OHTs that are approved that have LTC partners, and we are quite confident that the number actually has grown, and we are looking to capture the more current-state picture of all of

the partners across all of the OHTs.

And we have been working very closely in trying to emphasize the inclusion of LTC within Ontario Health teams as they come together, and we know that there is a lot of benefit that groups have seen to LTC being part of the participation, especially from early days. If you get in at the early stages, you'll definitely see a broader opportunity for partnership.

You know, we know that there are barriers to participation across many sectors that people have identified, and we are looking to kind of understand more about those so we can support their removal and support increased participation.

So we'll be increasingly working with our Ministry of Long-Term Care colleagues to identify those opportunities to support increasing their participation and work more to see how we can advance that. And I think hearing some stories about what has happened through COVID and what benefits have been extended will help with that along the way.

So on the next slide --

COMMISSIONER ANGELA COKE: Can I just ask a question?

ALLISON COSTELLO: Yes.

COMMISSIONER ANGELA COKE: You mentioned some teams have noted the systemic barriers to change that exists within long-term care. Do you have some examples of that?

ALLISON COSTELLO: For sure. And I don't know, Amy, if you wanted to start, or...?

AMY OLMSTEAD: Yeah. I think when we think about -- you know, we phrased it that way because we were looking at this -- this slide is focused on long-term care, but the barriers that long-term care or that any partners in any sector would face or see or be considering when they're looking at OHTs I think are quite similar.

Its legacy issues with respect to historical funding arrangements, separate accountability arrangements, a lack of a relationship sort of on the ground today would be some of the barriers that we see when we hear, you know, anecdotally from partners what they're considering. Yeah.

Allison, was there anything else on that? I think -- I mean, I think the questions would be -- you know, we hear things anecdotally, and they tend to be related to those issues, yeah.

COMMISSIONER ANGELA COKE: Mm-hm.

ALLISON COSTELLO: And I would say, you know, those that have partnered in cross-sectoral usually -- you know, specific pathway endeavours and seeing the benefit of that will see that the benefit outweighs the barriers and look to pursue more participation.

But where there haven't been as many partnerships or as many cross-sectoral interventions that people have tried before, they're not aware of what the benefit that could be extended to them is. So it's going to be a lot about knowledge translation and sharing information about what could be available to teams if they join in. All --

COMMISSIONER FRANK MARROCCO (CHAIR): So let me just ask --

ALLISON COSTELLO: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Excuse me. Just let me ask: Is the idea that the Local Health Integration Network will hold the teams accountable for what they've said they're going to do on a kind of practical basis, or is somebody else going to do that?

AMY OLMSTEAD: So at maturity, Ontario

Health will hold the funding for Ontario Health Teams and have that accountability relationship.

Currently, the Local Health Integration Networks continue to hold accountability agreements with many partners in the system. The government has indicated that, over time, the plan is to phase out the LHINs with their responsibilities transitioned to Ontario Health and some of their responsibilities transitioned to Ontario Health Teams. That will be a gradual process.

So it's obviously a theme in our discussion today in terms of the careful and planned and gradual transition to this model, and with respect to the role of LHINs, that's also underscored by the importance of continuity of care delivery, not just for home and community care and long-term care home placement which LHINs are responsible for delivering, and not just funding but for all aspects of the system that they would have oversight of.

But the end state, as I say, would be for Ontario Health to have that accountability relationship with Ontario Health Teams.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

ALLISON COSTELLO: So I'll move on to Slide 8. This is an overview of our work-to-date to establish Ontario Health Teams from the Ministry's perspective, and the concept of Ontario Health Teams was introduced in the legislation in February of 2019.

And we've kind of put some more meat on the bones of what that concept was through guidance we released that spring and opened up a staged process for approving OHTs, with an initial call for self-assessments in the spring of 2019 with over 150 different groups coming together at that point to indicate their interest in participating.

Based on that, we invited 30 teams to complete a full application and conducted a review of those applications over the fall, and then now it's the first 24 approved Ontario Health Teams in the winter.

We have been supporting teams that were otherwise -- you know, other teams that came through the 150 applicant groups, trying to understand kind of how to support them to achieve approval over time as well, which, in a lot of cases meant the eventual track for all 150 of those submissions was not to reach approval. There will

not be 150 teams; a lot of those applications didn't quite match the model.

But a number of them did, and we've been trying to work with all of those teams to support them, to achieve alignment with what we've set out and understand how to support their readiness. So that included progress reports from a number of teams in the fall to support another invitation to complete full applications that we were on track to do in the spring.

But we put a number of our OHT activities on pause in March and communicated to all teams that we were putting those things on pause to allow them to focus on COVID response and kind of turned "go" again in July, but we did reach out, and the next few slides will speak to that.

We reached out to every team in June and July to understand where they were as far as their implementation, understand what their COVID response had looked like, and also make sure that we heard from them what their capacity was to restart OHT activities.

And based on that, we did announce in July more teams that we were inviting to full application. We also announced approval of five

more teams that were from the first round of applications, and we announced that funding was available for approved teams that completed their collaborative decision-making attestation.

And we had a webinar in August that spoke to a lot more detail about each of those aspects, and we're hopeful to have an announcement shortly based on the review of the most recently submitted applications to the Ministry.

COMMISSIONER FRANK MARROCCO (CHAIR): And how many health teams do you anticipate there will be in the province?

ALLISON COSTELLO: We have not set a number distinctly, as we think it really will relate to how teams come together. We do have a sense of how many networks the data shows us, but we know that the teams may come together in different ways.

We know we've got 29 approved teams right now. We had 17 applications. So each of those 29 plus 17 reflected teams that were really aligned to what the data showed us as far as how they plan to care for a population at maturity, and beyond that, there are a number of teams that are not quite aligned, so a number of teams where there

might be three teams or three proposed teams within a network that shows us that it is one common population.

And we're trying to understand what the openness is of those teams coming together to support a coordinated approach for that population, and how that next phase of teams comes together will really help us determine what that end-state number is. So we have a vague sense but not a concrete one.

COMMISSIONER ANGELA COKE: Just to add on that, do you have any sort of preferred or desired time frame by which you would like this to be sort of the pervasive model across the province?

ALLISON COSTELLO: I would say we have not -- we have additionally not set a time by which all OHTs will reach their maturity, but we are very much -- and the minister announced in her announcement in July, in her participation in that August webinar, the ability to have some approved OHT activity in every network of the province based on this data is quite within reach.

We do have a sense that there is kind of activity in every area that we can support progression on. So we're trying to focus our

energy to support having an approved OHT within every network in the next few years, but again, those would be doing that preliminary work for an initial year-one population, not a fully mature population.

COMMISSIONER JACK KITTS: Allison, I think you've explained why these are so important, and I think the pandemic has put an exclamation mark on why healthcare providers must work together in the best interests of population. So nobody asks why we need OHTs, I don't think, anymore.

What they're trying to achieve is the quadruple aim, which I don't think there's any health system in the world that wouldn't agree that those are exactly what we need to do.

It seems that how to get there is where we're tripping over each other, and I understand that the initial was, here, we're going to create Ontario Health Teams; you show us how to create them in your local area because it really is all about relationships.

So my question is, if we're going to accelerate the development of them across the province, do you have any models right now that aspiring teams or developing teams or early teams

could learn from in terms of what worked, and with the pandemic, certainly would have given a good opportunity to see how a team worked? Do you have any that you can point to in the province for others to aspire to?

ALLISON COSTELLO: I think you've heard from some of them. Looking at the past transcriptions, we're very much -- we don't have that kind of common sense of reporting from every OHT to know the level of kind of their sophistication or what we've heard from -- or what they've been able to achieve through the pandemic.

We're working to build that, and we very much want to gain on the learning from teams that are really having successes in a number of domains. So there are a lot of, you know, LTC integration and support to LTC through COVID as one aspect, how people have supported better access to primary care to support their teams, virtual and other aspects that we want to set up the learning and really create that collaborative and knowledge translation and mentor-mentee and champions across all of these aspects to really support this was -- this worked. Everyone can learn from it, and then if it worked and everybody can learn from it, what

then about that that we might want to standardize or put in place as a given.

And we're still in that learning stages of trying to find out from teams about how they've been able to advance their work.

COMMISSIONER JACK KITTS: Well, we've heard from hospitals and public health and long-term care how those three came together to deal with crises in long-term care. I believe we've heard from Robert Garron, is it, the hospital?

ALLISON COSTELLO: Michael Garron, yeah.

COMMISSIONER JACK KITTS: Michael Garron.

ALLISON COSTELLO: Yeah.

COMMISSIONER JACK KITTS: And I think the CEO of the hospital there indicated that it was an Ontario Health Team that did that work.

But you have 29 identified Ontario Health Teams. Do you have more from those approved Ontario Health Teams that could be examples for others?

ALLISON COSTELLO: Maybe I --

AMY OLMSTEAD: Is it okay if I --

ALLISON COSTELLO: Maybe I can go to the next slide to speak to that because we absolutely do. And when we had had an outreach to the teams between June and July to kind of understand what restarting our OHT activity would look like, we really didn't want to be in the way, pulling attention inappropriately from the work they needed to do locally.

So we had heard from a lot of them, a pretty resounding response to not slow down our OHT work because it has supported the collaborative cross-sectoral effects to supportive pandemic response.

So we do have on this slide a number of examples of LTC being well supported through OHTs' activities, which is sometimes hospital-led, sometimes public health but sometimes primary care, or otherwise community partners being part of a broader collaborative, and the commitment that the Ministry has made to learn from those that are implementing first to really inform what to do next.

And certainly, we didn't anticipate it would be a pandemic that we would be learning from, but it has spurred a tonne of learning for us that

we want to really take hold and move to spread across OHTs, especially in those areas where they're most in need based on transmission rates and the like.

So this slide sets out certainly a lot of what you would have heard about IPAC advice to LTC volunteer emergency responses to support LTCs in need; tables that really are in place to strengthen the relationships across sectors; evacuation plans to support rapid and safe transfer of patients across homes; PPE distribution and acquisition across partner groups, including LTC; and critical staffing needs, that they could be supported across the broad-sector participation; and also virtual care being an enabling element of all of that.

So these are a sampling of the stories that we heard from the teams when we reached out in June and July from that, but really turning that into a learning system across all OHTs, across the 29 approved right now, and those that would be approved going forward. But also those that are not yet approved, there's a tonne of learning here as people are building together their preliminary work on an OHT table that we really do want to

support the learning across and best practices that should be in place.

The next few slides speak to more of the same, but I can definitely whiz through them quickly for any further questions we have.

But really, aligned with the message of wanting to learn from the implementation of OHTs to support what to do next, from the Ministry's perspective, from supporting OHTs, from building the agencies' response as well, as they're a key partner -- Ontario Health is a key partner in supporting OHTs as well.

So in addition to the calls that we took in June and July, we also have a number of support partners that are capturing information from OHTs, including evaluation partners that have been doing specific exploration of learnings through COVID across these teams. So we're highlighting a number of those as well.

So cross-provider partnerships that have really enabled a strong sectoral response, and I think one of the questions we heard earlier was about how nimble a response can be. And we definitely heard that the ability of these teams to move quickly when a problem came up and just have

everybody at the table and do it is really what we heard was in place across these structures.

We know that the regional tables across OH really supported coordination as well and some learnings as they were going. So if that was about moving patients out of hospital, creating new care pathways for at-risk and vulnerable patients, we heard a lot about that as well.

And at the bottom, you know, the Ministry's commitment to being flexible to the OHT implementation, that is really responsive to the system capacity which is balanced with so many teams sort of saying, this has been a crash course in population health management; responding to COVID is about caring for a full population, and we shouldn't be slowing down our OHT activity related to that.

However, we don't want to appropriately be pulling time and resources to work if it's needed locally. So we're really trying to take a balanced approach to our implementation going forward and building the supports that the teams will need to respond appropriately to COVID but also to advance their maturity overall.

And the last slide before the appendix

just emphasizes how we took some of those learnings into adjusting our process overall. One of the approaches we wanted to take was to be a little bit less onerous in the application process, so we did streamline it and emphasized through a revised application, encouraging teams to engage with Public Health in congregate care settings, including long-term care, to really support that regional response to COVID.

And we released some additional guidance, as we spoke to you about, decision-making, and have provided funding, as a lot of teams were having a real challenge keeping the engine going on the work that it takes to work together. So really listening to that feedback and building out the appropriate supports that they need.

COMMISSIONER JACK KITTS: Can I just ask a question on accountability? So I think Commissioner Coke asked about accountability within the teams, and so the collaborative approach.

So now within the teams, we have hospitals that report to the Ministry of Health, long-term care homes report to the Ministry of Long-Term Care, many report to Ontario Health, and

then there's Public Health with a different reporting relationship. So you've got four vested interests in terms of, I guess, governance and accountability.

Who is ultimately responsible for the success or managing the Ontario Health Teams?

AMY OLMSTEAD: In terms of responsibility for advancing Ontario Health Teams and seeing them through from development and implementation and maturity, that responsibility is with the Ministry of Health, and we're working very closely with our partners on that, including the Ministry of Long-Term Care. And Ontario Health does have the legislative authority at maturity to be overseeing those Ontario Health Teams as well.

So I think what you're getting at is the significant amount of work that needs to be done between now and then to work with the various partners in accountability to bring together a shared accountability framework for the OHTs.

COMMISSIONER FRANK MARROCCO (CHAIR): Does that pose a difficulty in terms of a coordinated approach to have that many primary partners?

AMY OLMSTEAD: I think it's reflective

of the complexity that we see in the health system in Ontario and in other jurisdictions as well.

You know, this is the government's direction with respect to Ontario Health Teams; it's not just the Ministry of Health's direction. So all of our partners within government and accountable to government are pulling in the same direction.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, I don't know. Was that the end of the presentation? Did I get that right?

AMY OLMSTEAD: Yes, that was it for our slides. There are a couple of slides in the appendix that I think we showed at various points as well. So happy to answer other questions, or if there is additional information that you'd like us to provide after we leave today, that's fine as well.

COMMISSIONER JACK KITTS: I just want to clarify that from what we've heard this morning -- and Allison, as you've said, we've heard from others -- why we need Ontario Health Teams' integrated care is quite evident to everyone. I don't think there's any debate about that, that that's better than the siloed system we have now.

What we've trying to achieve with them and the quadruple aim is no argument that that's -- that would define any world-class health system.

How we're going to get there, you are working extremely hard to build on the momentum and learnings from the pandemic and are committed -- I think I'm hearing the Ministry of Health, the Ministry of Long-Term Care, Public Health, and Ontario Health are all committed to getting these models up and running as soon as possible and will do everything they can to make that happen.

Is that a good summary of what we just discussed in the past hour?

AMY OLMSTEAD: Yes, another excellent summary. Yeah, exactly.

COMMISSIONER FRANK MARROCCO (CHAIR): What's your estimate of when the start-up process -- if that's the correct way of referring to it -- will have completed itself?

AMY OLMSTEAD: In terms of -- and, I mean, I think we're already well into our start-up process. If we're thinking of having an OHT that's supporting all parts -- all people in the province, again, we haven't established a timeline, but we've made tremendous progress on it in just the past

year or so.

So I don't think, again, we've put any timelines on. We have to be flexible with respect to the pandemic and continuing to encourage the local momentum and reinforcing that with the right incentives on our end.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, unless there are any other questions? I don't see -- I don't think there are. Thank you very much. There's been a fair bit of discussion amongst ourselves about Ontario Health Teams, and not just from Commissioner Kitts but from all three of us, and this has been very helpful in putting us all in the picture as far as they're concerned. So thank you very much.

AMY OLMSTEAD: Well, thank you very much for your time and your questions.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Goodbye.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: Thank you.

AMY OLMSTEAD: Thank you.

-- Adjourned at 11:59 a.m.

REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, CSR, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 16th day of November, 2020.

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